REQUEST for STAKEHOLDER COMMENT
Design and Development of an Insurance Exchange in Connecticut

The following information is organized by general topic area, with a list of questions we would like you/your organization to answer as you feel appropriate. These questions are followed by background briefings to provide a general understanding of the topics. To encourage productive discussion during each meeting, we are providing you this information in advance of your meeting. While these topic areas are the specific issues for which public comment is requested, please feel free to offer any other comments on policies related to the Exchange and the insurance market as well.

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QUESTIONS

Please provide us with your thoughts and insights on the questions listed below as you feel appropriate.

A. Establish a Responsive and Efficient Structure

1. Should Connecticut consider joining a multi-state Exchange? Under a regional Exchange, would Connecticut benefit most from a separate or merged risk pool?

CT should explore the multi-state option with surrounding states to see if it's a viable option; it depends on the risk pool of the other states. Discussions should be had within and between state insurance departments. Remember, prior loss experience is an important factor to consider.

2. Should Connecticut administer the Exchanges for the individual and small group markets separately or jointly? If jointly, should Connecticut maintain separate risk pools for the two Exchanges, or merge the risk pools.

Is CT already a merged market? If so, this is not a huge issue. If they are not merged, one should review the risk profile to see if it makes sense to combine. It is probably best to keep separate in the early years and wait to review that option down the road. These markets are like apples and oranges, generally there needs to be a distinction made, which is why insurance companies currently treat them differently.

3. Should Connecticut open the Exchange to businesses with 2-100 employees in 2014, or should it allow businesses with 2-50 employees in 2014 and increase participation to businesses with 51-100 employees in 2016?

If CT is structured with a 2-50 today, then that's the safest bet but it could be beneficial to review the option of opening it to 100 lives. Many employers hover around 50 and if the exchange is viable, they may want the option of buying through the exchange. Again, it is safer to start small and see where things are in a couple of years. Connecticut may also want to build in a structure under which small businesses are not flipped in and out every time they go above or below 50 employees. Maybe a time period should elapse before a switch is triggered. Maybe a range allowing you to join under 50 and stay in as long as you don't hit 70 or 80 or whatever; kind of like a thermostat with a few degrees give in either direction.

4. Should Connecticut seek to expand access to businesses with more than 100 employees in 2017, with HHS approval?

Answer is the same as #3. Once you begin to open to larger groups, more things come into play. It is possible the larger the employer, the more stable the risk profile. NFIB would advise a review of the risk impact this option does to the exchange. Also, is there a cost factor and who pays if so? Need to fully assess and document the need before moving in this direction, such a decision can't and shouldn't be made up front. Should also look at why so many large groups have sought and are seeking waivers from the federal bill – perhaps they are happy where they are? Again, need to look at who is seeking the coverage, and build gradually.

B. Address Adverse Selection and the External Market

1. Should Connecticut allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange? Under a dual market scenario, what additional rules should Connecticut establish to prevent insurers from discouraging participation in the Exchange? What hybrid models might Connecticut consider, and what characteristics do they offer that would benefit Connecticut?

CT should allow a dual market. There should be an inside/outside marketplace. The problem arises with the fact that subsidies are only available in the exchange and that alone will steer the marketplace. The small business tax credit also only lives in the exchange and that was purposeful. The free-rider (employer mandate) is another costly and burdensome mandate for employers. These issues will complicate and could harm the exchange. CT should make both markets attractive to insurance carriers. Carriers should be allowed to operate in both places and should only be required to comply with minimum essential coverage requirements. If the state screws up the exchange and no one answers the telephones, for example, you want the private market to remain viable.

2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange?

Yes, basically anything that further steers purchasers to a certain marketplace, as there will be problems. There are fundamental concerns with the underlying law that must be addressed. In the meantime, CT should not make that problem worse. Requiring heavier benefits in the exchange, having a government negotiating exchange and/or creating a highly restrictive exchange will harm the market in CT. The underwriting function is how insurance currently mitigates adverse selection and changes accordingly. Also, any thoughts given to having optional health/wellness programs to help make healthier individuals?

3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms?

It is necessary to have a reinsurance program. This should be a state DOI function; need to make sure programs are actuarially sound, assets and resources need to be sufficient.

C. Simplify Health Insurance Purchase

1. What issues should Connecticut consider in establishing a Navigator program?

Allow multiple populations to access the navigator role. This should be viewed as both an education tool but also one that showers the consumer with easy information and options. There should be consideration given to brokers and agents who currently operate in this area as they are the ones currently serving the small business population There's some anti-broker sentiment in some states, with people specifically wanting navigators with no broker background. This approach is very unwise. They do understand the market better than most, and consumers might not want to get their advice from someone with no such background. At the same time, we don't want to limit it to just brokers. However, this should just be given away either, need to make sure there are "certified" people, who are trained, licensed, etc. Where does state DOI come into play here?

2. What should Connecticut consider regarding the role of insurance brokers and agents?

As said above, CT should review how broker and agents are used and build in that area. A new focus for agents and brokers could also be a larger more robust individual market. Individuals will require assistance whether they are purchasing inside or outside the market. And if small business or individuals feel they can purchase on their own with an agent, then they should be allowed to do that as well. Remember, brokers and agents can act as a stop gap, and they assist with explanation.

D. Increase Access to and Portability of High Quality Health Insurance

1. Should Connecticut allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should Connecticut establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?

No additional requirements; currently, any company/plan that meets state DOI requirements is eligible to write, so why change the standards? Yes, any plan that meets QHP should be allowed to operate in the exchange. If the state starts picking and choosing, it becomes unstable and also potentially could become a political football.

2. Should Connecticut consider establishing the Basic Health Program? What would the Basic Health Program offer as a tool to facilitate continuity of coverage and care?

No.

3. How would the Basic Health Program impact other related programs in Connecticut?

No, don't do a BHP. Volatility.

4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)

This is an area in the federal statute that is very flawed. This will be a huge problem for individuals, employers and their employees. Month to month, individuals can jump in and out of

eligibility of Medicaid and private coverage. This must be fixed. It is a major problem anytime you start moving people in and out, and programs are often incompatible. Also, if a broker did this to a client and didn't explain it, they would be subject to an E&O claim.

E. Ensure Greater Accountability and Transparency

1. What information should Connecticut include for outreach to most effectively engage consumers? How should the information be presented?

The information needs to be precise, transparent, and simple. Keep those goals in mind first and foremost. The information should probably be designed by outsiders – perhaps from the consumer-driven health plan community. State government officials in general and "bureaucrats" are probably not the best at designing such. CT might also want to facilitate competitive designers. If the official portal stinks, then it might be good to allow competitors to offer alternatives. Of course, that raises consistency and privacy issues, but someone who knows the market can deal better with it. In a sense, we currently have competing portals in that some brokers create their own "Travelocity"-type insurance purchase sites. (Think of Progressive Car Insurance). Information and outreach needs to be conducted by all means possible as well. Consumers/purchasers also specifically need to be made aware of pros and cons in order to make an intelligent and informed decision.

2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?

There should be a requirement for formal comments; and also you need to make sure the business community is involved throughout the design, implementation and operation, the small business community in particular. We are, after all, the payers. Also, what is the role of DOI here? Should they audit and certify the program? Finally, if there are operational issues, you'll certainly hear from consumers.

3. What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?

Capital adequacy; the usual insurance stuff, etc. Whatever criteria that state has today should be sufficient. Why load it down with more requirements? Perhaps a comparison with the private market would be particularly helpful though, i.e. think Medicare supplement brochure – looking at one program to the next, or a spreadsheet approach.

F. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015?

CT needs to be very cautious about taxing the employer community for any of the exchange costs (especially in light of the recent state budget/tax package). The employers, small employers specifically, are the people this structure was suppose to help. Parts should be financed by purchasers – not by general taxation. Otherwise, it can transmogrify into a subsidy mechanism. Think of the usual manner, premium payments are made by the users of a program. Leave it up to each employer to determine if they will share the premiums with their employees, as they currently have the freedom to do. Subsidized premiums will destroy the tax system.

2. How might the state's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange; and affect accountability, transparency, and cost-effectiveness?

Running the exchange well should be of utmost importance, and it will impact the reputation of the exchange aside from financing strategies. Financing should not focus on encouraging participation; it doesn't make sense to try to "bribe" people into participating, which would also certainly affect the reputation. Also again, what role does DOI play here? Need to ensure that premiums are greater than losses, etc.

3. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?

Minimum essential coverage is already too high and will be difficult for people to purchase without heavy subsidies. The average buy up for individual's coverage according to CBO is 10-13% already. There is no need to have more benefits on top of the federal requirements. For how many years have CT's small businesses have been and continue to be at a disadvantage compared to other states because of the large number of state mandated benefits? This is an opportunity to help remedy what is a major problem for CT's small employers and individuals. If at some point in the future anything beyond the minimum is considered, it should be done very slowly, factoring in the impact and losses first, and premiums should be increased (not additional subsidies) to reflect additional benefits.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

1. Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?

Consider premium aggregation. Allowing part-timers to bring their dollars together from multiple employers to purchase health insurance. Allow a full voucher option - where the employer makes a defined contribution to the employee, and the employee can then purchase coverage in the individual market exchange. Any amount would buy down the premium subsidy (assuming they are eligible) and would therefore save money. As for regulatory oversight, again, focus on DOI role. Why reinvent the wheel and/or ignore their existing function(s)?

2. Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

No limits. Let the market decide. "Any willing provider" is the better way to go (so long as qualified, able to pay claims, etc.).

3. Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?

NO NO NO!. All of these are *terrible* ideas for the employer community. This will hinder job growth and hinder coverage offerings. Stay away from touching minimum employer contribution. This is a negotiable item/benefit between employers and employees, don't alter this. Limits on the range are a bad idea – if it all becomes uniform, and you don't have an array of products in the exchange, why would anyone select company A over company B?

4. What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?

Anything that lowers their current costs could be considered helpful. A competitive price is necessary. Flexibility is only good if the employer can actually afford to offer coverage. The

more employers pay out for benefits, the less they pay in wages. Easy of entry needs to be considered as well, and there need to be clear administrative requirements and processes. Small businesses already have a huge regulatory/paperwork/administrative burden and often lack the sophistication/personnel as compared to larger companies in administering benefits, etc. Businesses can't afford and shouldn't have to hire another HR person. Claims payments and handling need to be done with speed.

5. What should be the role of the Exchange in premium collection and billing?

Administrative and to use the most effective approach. Some businesses are skeptical and think it should only be handled by whoever the players in the market are.

6. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?

Does anyone know? Ask Massachusetts and Utah, because there are few other guidelines. Might also ask places like California where previous exchanges failed. What does DOI think as well?

BACKGROUND by TOPIC AREA

The general information on each topic area below is intended for brief reference only.

A. Establish a Responsive and Efficient Structure

The ACA requires that all states establish an American Health Benefits Exchange for the individual market and a Small Business Health Options Program (SHOP Exchange) for the small group market. States may operate these independently or may combine them into a single Exchange. States may also form regional or multi-state Exchanges.

For the purpose of inclusion in the SHOP Exchange, the ACA defines small employers as an employer with 2-100 employees. However, until 2016, states may limit this definition to 2-50 employees; and after 2017 states may further expand participation in the SHOP Exchange.

B. Address Adverse Selection and the External Market

The ACA allows states to establish a "dual market" in which individual insurance may be purchased in and out of the Exchange, or to require that all health insurance plans sold on the individual market must be sold through the Exchange. States may also design "hybrid" solutions such as permitting supplemental coverage to be sold in external markets but requiring that all individual major medical coverage be sold in the Exchange.

The ACA establishes certain rules to protect against selection issues in a dual market, but does not deny states the ability to include additional requirements for insurance sold in the Exchange and an external market. State options include but are not limited to requiring that all insurers in the Exchange offer all four tiers of coverage, standardizing benefits packages, and restricting the sale of "catastrophic" insurance plans. However at a minimum, the following rules apply:

- Plans inside and outside of an Exchange must be in the same risk pool, have the same premium rate (for those sold by the same company), and meet the same minimum benefits standards.
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre- existing conditions, medical status, or claims history.
- Premium variation based on age, geographic location, and smoking status must apply to plans sold both inside and outside the Exchange.
- Plans sold in the Exchange must have an open enrollment period and special enrollment periods to encourage participants to purchase coverage before they become sick.

The ACA requires that states establish a reinsurance program for the individual market inside and outside of the Exchange, for the first three years of Exchange operation. The NAIC will develop model legislation to carry out this provision. States must consider issues such as how to coordinate their high risk pools with this program.

C. Simplify Health Insurance Purchase

The ACA requires an Exchange to establish a "Navigator" program to conduct public education, advise individuals and small groups that enroll in the Exchange, help them enroll in health plan and access benefits, and provide referrals as needed to the health care ombudsman. The Navigator program must be established by awarding grants to a variety of groups, and must be financed through operational funds of the Exchange (not Federal funds received by the state to establish the Exchange).

With establishment of an Exchange, the existing relationship between brokers, carriers, and consumers is likely to change. The ACA leaves states flexibility to make decisions regarding these relationships, such as designating an official role for brokers within the Exchange apparatus, requiring certification, or regulating commissions.

D. Increase Access to and Portability of High Quality Health Insurance

The ACA requires that health plans that wish to participate in an Exchange (Qualified Health Plans) comply with certain requirements related to marketing, choice of providers, plan networks, and essential health benefits. Beyond this, states may establish additional requirements for plans that are offered on an Exchange.

The ACA provides states with the option of operating a Basic Health Program for individuals between 133% and 200% of the federal poverty level, in lieu of those individuals receiving premium subsidies for purchase of coverage. The benefits under the Basic Health Program must be at least equivalent to the essential health benefits and premiums may not be higher than those in the Exchanges.

With health care reform, individuals may be eligible for one of a variety of insurance options: Medicaid, CHIP, subsidized coverage through an insurance Exchange, and unsubsidized coverage through an Exchange. The ACA requires that there should be a single seamless process of applying for coverage for all of these programs – regardless of where a consumer enters the system.

E. Ensure Greater Accountability and Transparency

The ACA requires that Exchanges post information on the cost and quality of health plans. Specifically, states must develop an Internet website for standardized comparative information on plans, provide public ratings of participating Exchange plans, and use a standard format for presenting health plan options in the Exchange.

F. Self-Sustaining Financing

The ACA includes grant funding for planning and establishment of Exchanges, but beginning January 1, 2015, state Exchanges must be financially self-sustaining.

The ACA establishes a minimum essential benefit set to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of those benefits for individuals eligible for tax credits through an Exchange.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

Under federal law, the Exchange is required to perform these functions:

- Certify, recertify, and decertify qualified health benefits plans under the guidelines established by the federal Department of Health and Human Services (HHS)
- Operate a toll-free customer assistance hotline

- Maintain a website that allows customers to compare qualified health benefits plans offered by different insurance carriers
- Assign a rating to each qualified health plan under the rating system that will be established by HHS
- Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions
- Inform individuals about the existence of—and their eligibility for—public programs, including but not limited to Medicaid and Children's Health Insurance Program (CHIP)
- Certify individuals who are exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS
- Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded due to a failure on the part of a small employer to provide sufficient affordable coverage
- Provide information to employers on their employees who are not covered
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits